NEBRASKA RURAL HEALTH ADVISORY COMMISSION'S

Annual Report

Nebraska Rural Health Systems and Professional Incentive Act

DECEMBER 2013

Review of the Nebraska rural health incentive programs and recommendations of the Rural Health Advisory Commission.

Nebraska Rural Health Advisory Commission
November 2013

Name / Affiliation	Appointment Designation
Commission Chairperson: Martin L. Fattig, C.E.O. Auburn, NE	Rural Hospital Administrator
Commission Vice-Chairperson Rebecca A. Schroeder, Ph.D. Curtis, NE	Rural Mental Health Practitioner
Scot L. Adams, Ph.D., Director NE DHHS – Division of Behavioral Health Lincoln, NE	NE Department of Health & Human Services
Brian K. Buhlke, D.O. Central City, NE	Rural Physician
Mark D. Goodman, M.D. Department of Family Medicine Creighton University Medical Center Omaha, NE	Medical School Representative
Jessye Goertz Berwyn, NE	Rural Consumer
Lisa Mlnarik, MSN, APRN-BC, FNP Clearwater, NE	Rural Nurse
Noah Piskorski, D.D.S. Burwell, NE	Rural Dentist
Mary Kent Humboldt, NE	Rural Nursing Home Administrator
Jenifer Roberts-Johnson, Chief Administrator NE DHHS – Division of Public Health Lincoln, NE	Designee for Director, Division of Public Health NE Department of Health & Human Services
Avery L. Sides, M.D. Omaha, NE	Family Practice Resident
Michael A. Sitorius, M.D.; Chairman Department of Family Practice University of Nebraska Medical Center Omaha, NE	Medical School Representative
Roger D. Wells, PA-C St. Paul, NE	Rural Physician Assistant

Staff Assistance Provided by: Marlene A. Janssen, RHAC Executive Director
Nebraska Department of Health and Human Services
Office of Rural Health
P.O. Box 95026
Lincoln, NE 68509-5026
(402) 471-2337
http://dhhs.ne.gov/publichealth/Pages/hew_orh.aspx

Nebraska Rural Health Advisory Commission's
Annual Report
of the
Nebraska Rural Health Systems and Professional Incentive Act
December 2013

EXECUTIVE SUMMARY

- The Rural Health Systems and Professional Incentive Act, passed in 1991, created the Rural Health Advisory Commission, the Nebraska Student Loan Program and the Nebraska Loan Repayment Program.

- The thirteen (13) members of the Rural Health Advisory Commission are appointed by the Governor and confirmed by the Legislature.

- The Rural Health Advisory Commission's statutory duties include, but are not limited to, establishing state-designated shortage areas, awarding rural student loans and loan repayment to eligible health professionals, and preparing recommendations to the appropriate bodies to alleviate problems in the delivery of health care in rural Nebraska.

- The Nebraska Student Loan Program provides *forgivable* student loans to Nebraska medical, dental, physician assistant, and graduate-level mental health *students* who agree to practice an approved specialty in a state-designated shortage area.

- The Nebraska Loan Repayment Program assists rural communities in recruiting and retaining primary care health professionals by offering state matching funds for repayment of *health professionals'* government or commercial educational debt.

- Nebraska was one of the leaders nationally when these state-funded rural incentive programs were initiated; however, funding has not kept pace with the demand. In addition, the rural incentive programs have expanded due to increases in the amount of the awards and the inclusion of more specialties without additional funding. The state appropriation, award amounts, and health professions eligible for the rural incentive programs all need to be expanded due to increasing educational debt and demand for all health professions.

- As of September 2013, there are 96 rural incentive program recipients practicing under obligation in Nebraska.

- The Nebraska Loan Repayment Program has an 89 percent success rate of recipients completing their practice obligations.

- The Nebraska Student Loan Program buyout rate has dropped from an average of approximately 50 percent in 1998 to the current average of 14.4 percent.

- Based on county population, the rural health incentive programs currently impact over 800,000 people[1] living in Nebraska in underserved areas by providing them access to health care professionals.

- According to studies on the economic impact of rural health care, "One primary care physician in a rural community creates 23 jobs annually. On average, 14 percent of total employment in rural communities is attributed to the health sector."[2]

- The importance of the state-funded rural incentive programs is reflected in comments received recently from recipients.
    - *"…providing compensation to those who practice in under-served areas in rural Nebraska…improves the level of care to those served in these areas."*
    - *"This program has made moving to a rural area a viable option…"*
    - *"The rural incentive program has been a tremendous help to me…and will benefit the local community. …I have been able to make…substantial principal payments on my student loans. This means that I have a greater capacity to reinvest in and update the practice…"*
    - *"I wouldn't trade living out here for nothing…"*
    - *"We had never considered setting up practice anywhere other than the Omaha area. When the opportunity came up for a position in rural Nebraska we…initially blew off the idea. We then looked more into the benefits of working in a smaller community and the Nebraska rural incentive program. This program was definitely a factor in the decision. We never knew how much our family would love this small town life!"*

[1] Based on county populations.
[2] Doeksen, G.A., St. Clair, C. F., and Eilrich, F.C. "Economic Impact of Rural Health Care." National Center for Rural Health Works, www.ruralhealthworks.org, September 2012.

History

The Rural Health Systems and Professional Incentive Act (the Act) was passed in 1991 creating the Rural Health Advisory Commission, the Nebraska Student Loan Program, and the Nebraska Loan Repayment Program. It should be noted that State of Nebraska employees are not eligible to receive benefits under the rural incentive programs.

Rural Health Advisory Commission

The Rural Health Advisory Commission is a governor-appointed commission consisting of thirteen members as follows: (1) the Director of Public Health of the Division of Public Health or his or her designee and another representative of the Nebraska Department of Health and Human Services; and (2) eleven members appointed by the Governor with the advice and consent of the Legislature. These eleven members include one representative of each medical school located in the state involved in training family physicians, one physician in family practice residency training, one rural physician, one rural consumer representative, one rural hospital administrator, one rural nursing home administrator, one rural nurse, one rural physician assistant, one rural mental health practitioner or psychologist licensed under the requirements of section 38-3114 or the equivalent thereof, and one rural dentist. *(NE Revised Statutes Section 71-5654**)***

The purpose of the Commission is to advise the Nebraska Department of Health and Human Services – Division of Public Health, the Legislature, the Governor, the University of Nebraska, and the citizens of Nebraska regarding all aspects of rural health care and to advise the Nebraska Office of Rural Health regarding the administration of the Rural Health Systems and Professional Incentive Act. *(NE Revised Statutes Section 71-5655)*

By statutory authority the Commission has the following powers and duties: (1) advise the Nebraska Department of Health and Human Services – Public Health Division (department) regarding the development and implementation of a state rural health policy; (2) advise the department and other appropriate parties in all matters relating to rural health care; (3) serve as an advocate for rural Nebraska in health care issues; (4) maintain liaison with all agencies, groups, and organizations concerned with rural health care in order to facilitate integration of efforts and commonality of goals; (5) identify problems in the delivery of health care in rural Nebraska, in the education and training of health care providers in rural Nebraska, in the regulation of health care providers and institutions in rural Nebraska, and in any other matters relating to rural health care; (6) *prepare recommendations* to the appropriate bodies to alleviate the problems identified; (7) advise the department regarding the Rural Health Systems and Professional Incentive Act; (8) designate health profession shortage areas in Nebraska; and (9) select recipients of financial incentives available under the Act. *(NE Revised Statutes Section 71-5659)*

Nebraska Rural Student Loan Program

In 1979, the State of Nebraska began awarding low-interest loans to medical students who agree to practice in shortage areas. Due to legislative changes over the years, the Nebraska Rural Student Loan Program now awards ***forgivable*** student loans to Nebraska medical, dental,

physician assistant, and graduate-level mental health students who agree to practice an approved specialty in a state-designated shortage area. Approved specialties are defined as follows: medical and physician assistant students must agree to specialize in family practice, general surgery, general internal medicine, general pediatrics, obstetrics/gynecology, or psychiatry; dental students must agree to specialize in general practice, pediatric dentistry, or oral surgery; and mental health students must be enrolled or accepted for enrollment in a training program that meets the educational requirements for licensure by the Department of Health and Human Services for "licensed mental health practitioner" or "licensed psychologist".

The Nebraska Rural Student Loan Program is for Nebraska residents attending graduate college in Nebraska. Student loan recipients receive a forgivable educational loan while they are in training in exchange for an agreement to practice in a state-designated shortage area the equivalent of full-time for one year for each year a loan is received. The number and amount of student loans are determined annually by the Rural Health Advisory Commission based on state funding.

Dental students were added to the Nebraska Student Loan Program in 2000 and graduate-mental health students were added in 2004. In 2000, the Legislature also passed legislation that increased the maximum amount of student loan awards for medical and dental students to $20,000 per year. The maximum amount of physician assistant student loans was increased to $10,000 per year. When graduate-level mental health student loans were added in 2004, the maximum amount of a student loan for a doctorate-level mental health student was set at $20,000 per year and for a master-level mental health student, it was set at $10,000 per year. Since 2009, the Rural Health Advisory Commission has awarded student loans at the maximum amount of $20,000 for doctorate-level students and $10,000 for full-time master-level students.

Nebraska Loan Repayment Program

In 1994, the Nebraska Legislature appropriated funding for the Nebraska Loan Repayment Program for health professionals willing to practice in a state-designated shortage area. Initially only physicians, nurse practitioners, and physician assistants practicing one of the defined primary care specialties, clinical psychologists, and master-level mental health providers were eligible for loan repayment. In 1998, pharmacists, occupational therapists, physical therapists, and dentists were added to the program. The approved specialties are the same specialties defined under the Nebraska Student Loan Program listed previously.

The Nebraska Loan Repayment Program requires community participation in the form of a local match and a 3-year practice obligation for the health professional. Communities must do their own recruiting, using the availability of the loan repayment program as a recruitment and retention tool. Once a health professional is recruited a local entity and the health professional must submit loan repayment applications to the Rural Health Advisory Commission.

State-Designated Shortage Areas

The Rural Health Advisory Commission has the responsibility of establishing guidelines and identifying shortage areas for purposes of the Nebraska rural incentive programs for the primary care specialties defined in the Act. Every 3 years a statewide review of all the shortage areas is

completed. If changes occur in an area during the years between the statewide reviews, the community may request a shortage area designation from the Commission. Any data or information submitted for review is verified by the Nebraska Office of Rural Health and University of Nebraska Medical Center – Health Professions Tracking Services. If the area meets the guidelines for state designation, the Commission may designate it.

Criteria for the federal and state designations differ and are used for different federal and state programs. Nebraska Office of Rural Health staff can assist with the data requirements and benefits of the various shortage area designations and incentive programs. Guidelines for the state-designated shortage areas and the current federal and state shortage areas are posted on the Nebraska Office of Rural Health webpage.

While the Nebraska rural incentive programs primarily focus on *rural* shortage areas Federally Qualified Health Centers (FQHCs) may request to be designated as state-designated shortage areas for family practice and/or general dentistry. As a state-designated shortage area, FQHCs may then qualify for benefits under the state incentive programs in addition to *federal* health professional incentive programs.

The Nebraska Office of Rural Health works to maximize state funds for areas not eligible for the benefits under the federal incentive programs due to practice area or practice specialty eligibility. Health professionals who are eligible are encouraged to apply first for the National Health Service Corps (NHSC) Loan Repayment Program before applying for the Nebraska Loan Repayment Program. Due to the recent reduction in funding and the use of Health Profession Shortage Area scoring for the federal NHSC Loan Repayment Program, health professionals practicing in Nebraska FQHCs are finding it difficult to be accepted in the federal loan repayment program. This has led to an increase in the number of health professionals applying for the Nebraska Loan Repayment Program which has created a waiting list for loan repayment due to more demand for the limit state funds.

Analysis of the Rural Incentive Programs

Chart 1 on page 7 shows graphically the number of rural incentive recipients by program receiving payments by fiscal year. The current fiscal year (FY2013-14) shows awards as of November 1, 2013. As long as state funds are available, additional loan repayment awards will be made by the Commission before the end of the fiscal year.

Several factors influence the number of incentive recipients each year. These factors include the amount of state funds available, the amount of each individual incentive award, and the educational level of the recipients. As one commission member stated, *"of all the programs, these are the most successful and the money comes back many times over."* The demand for the rural incentive programs remains high and total student loan debt is continuing to rise each year.

Chart 2 on page 8 shows the budget amounts by source for each fiscal year. Comparing Charts 1 and 2 demonstrates the increase in FY2008-09 of recipients and budget. In FY2008-09 the Legislature increased the rural incentive program budget by $250,000 per year for 4 years. This funding increase was from the Merck Settlement in the form of cash. The Legislature provided

for the use of $250,000 from the Merck Settlement each of four years for the state match for loan repayment and $250,000 per year in "cash spending authority" for the local match funds required for the Nebraska Loan Repayment Program.

Beginning July 1, 2013, the Legislature transferred $1.5M to from the Department of Health and Human Services cash fund and moved it to the Rural Health Incentive Fund. Cash spending authority was granted to use $500,000 of this money for each of the next two years for the state match for loan repayment. In addition, the Legislature authorized spending authority for the local match funds in the same amount as the state match. (This is essential for the loan repayment program because this program requires a 50-50 state and local match.)

Beginning in FY2009-10, the Rural Health Advisory Commission began awarding student loans and loan repayment at the maximum levels of $20,000 or $10,000 per year depending on the educational level of the recipient. This resulted in fewer awards but assisted rural communities in being able to compete with larger communities to recruit and retain health professionals.

Chart 3 on page 9 shows the dollar amount of rural incentive awards by program by fiscal year. Student loans are awarded by the Rural Health Advisory Commission in June prior to the beginning of each fiscal year; therefore student loans are projected for fiscal years beyond FY2013-14.

Loan repayment awards are made at each Rural Health Advisory Commission meeting as applications are received and state funds are available. Loan repayment requires a 50-50 local-state match and cash spending authority to spend the local match. Loan repayment awards will continue to be made during FY2013-14 as long as state funds are available and eligible applications are received.

Chart 4 on page 10 gives another perspective to the loan repayment awards. Since loan repayment requires a 50-50 state-local match, Chart 4 shows the funding impact of loan repayment awards by fiscal year. The increase "bump" beginning in FY2013-14 is the addition of the cash funds transferred to the rural incentive cash fund.

The Nebraska Loan Repayment Program requires a 3-year practice obligation so when the Rural Health Advisory Commission awards loan repayment the obligation of funds is projected over the 3-year practice obligation. Loan repayment awards being made in FY2013-14 will impact the rural incentive program budget in FY2014-15, FY2015-16, and FY2016-17; hence the future budget obligations shown on Chart 4.

Charts 5 and 6 on pages 11 and 12 show the number of recipients by profession by fiscal year for the Nebraska Loan Repayment Program and Nebraska Student Loan Program; respectively. While more medical professionals use the loan repayment program than the other eligible health professionals, the Nebraska Student Loan Program has been a good program for dental students interested in rural practice. Unlike the Nebraska Loan Repayment Program, student loan recipients do not have to find a local agency to match the state loan repayment funds and they can be self-employed and still receive forgiveness of their rural incentive student loans. Chart 6 also shows an increase in the number of physician assistant students receiving student loans.

This is in part due to the number of qualified applicants especially from one of the physician assistant training programs in Nebraska that is promoting the Nebraska Student Loan Program to their students.

Table A on page 13 shows the number of student loan awards issued each year from FY2004-05 through FY2013-14. Since FY2004-05, the Rural Health Advisory Commission has awarded an average of 8 new student loans and 9 continuation student loans per year. New student loan awards are based on the quality of applicants each year and the likelihood that the applicant will return to a rural shortage area to practice.

Prior to 1998, buyout rates for student loans, historically, averaged about 50 percent. Given four years of medical school and at least three years of residency training, a medical student loan recipient will not be available to practice in a shortage area for up to seven or more years. To improve the success rate of recipients fulfilling their practice obligations, administrative changes were implemented in 1998 to remind student loan recipients of their practice obligation. Then in 2007, the Rural Health Advisory Commission recommended a legislative change to reduce the buyout rate for student loan recipients from 24% simple interest from the date the loan was received to 150% of the principal plus 8% at the time of default. During the most recent 5-year period (FY2005 – FY2009), for which data are available, the buyout rate has dropped to an average of 14.4%.

Table B on page 14 provides a summary of the Nebraska Loan Repayment Program from 1994 through 2013. Since 1994, 453 health professionals have participated or are participating in the Nebraska Loan Repayment Program. Ninety-one percent (91%) of loan repayment recipients have completed their practice obligation or are currently serving their practice obligation. Less than 8% of loan repayment applicants have defaulted on their practice obligation. As of November 2013, there are 100 *loan repayment* recipients in practice under obligation in rural or underserved areas of Nebraska with more to be added as awards are made and contracts are signed.

The map on page 15 shows the practice location of rural incentive recipients as of September 2013 and includes the Legislative District outlines. At that time 96 licensed health professionals were in practice under obligation.

Highlights of the Rural Health Advisory Commission's Recommendations

Each year the Rural Health Advisory Commission – Policy Committee reviews and prepares recommendations to assist in alleviating problems in the delivery of health care, in the education and training of health care providers, in the regulation of health care providers and institutions, and in any other matters relating to rural health care in Nebraska. The 2013 Annual Rural Health Recommendations (March 2013) includes the following focus areas:

1. Incentive Programs for Rural Health Professionals;
2. Behavioral Health Services;
3. Integrated Service Delivery and Training Systems;
4. Rural Emergency Medical Services;

5. Rural Communication and Information Technology Systems;
6. Rural Quality;
7. Strengthening Rural Health Services by Improving Access to Affordable Health Care;
8. Rural Managed Care and Reimbursement;
9. Veterans Care; and
10. Elderly.

In the 2013 recommendations report, the Commission identified the needs within each of the focus areas and support for each of the recommendations. The Rural Health Advisory Commission's Annual Rural Health Recommendations, March 2013 report is attached as Appendix A beginning on page 16.

Summary

As a result of both the rural incentive programs, as of September 2013, there are 96 licensed health professionals in practice under obligation providing access to health care services for over 800,000 people living in Nebraska. These two rural incentive programs (student loans and loan repayment) are the only state-funded programs of this type to encourage health professionals to practice in state-designated shortage areas. The only limitation to these programs is the level of the state appropriation.

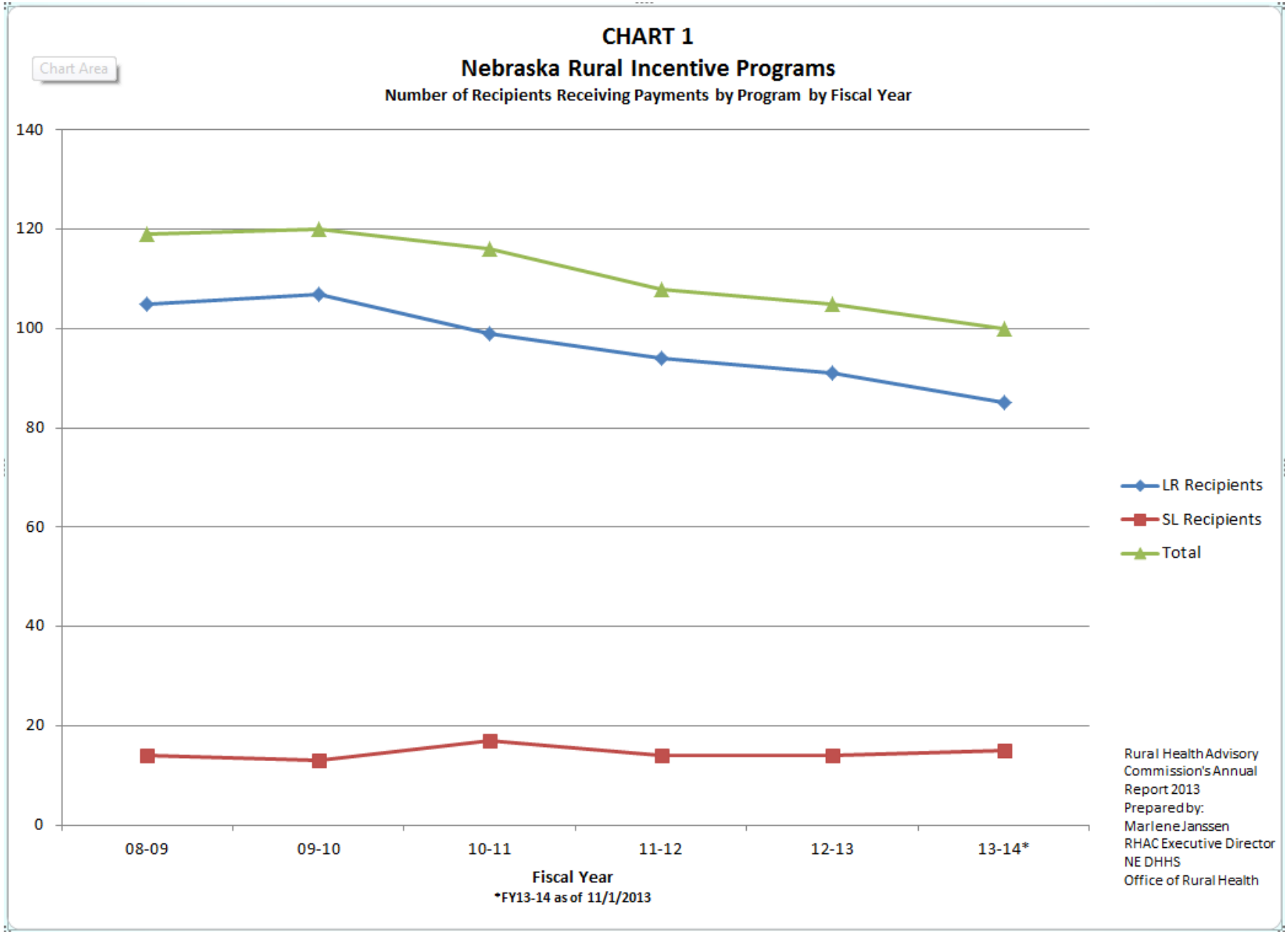


CHART 1
Nebraska Rural Incentive Programs
Number of Recipients Receiving Payments by Program by Fiscal Year
Chart Area
140
120
100
80
60
40
20
0
08-09
09-10
10-11
11-12
12-13
13-14*
Fiscal Year
*FY13-14 as of 11/1/2013
LR Recipients
SL Recipients
Total
Rural Health Advisory Commission's Annual Report 2013
Prepared by:
Marlene Janssen
RHAC Executive Director
NE DHHS
Office of Rural Health

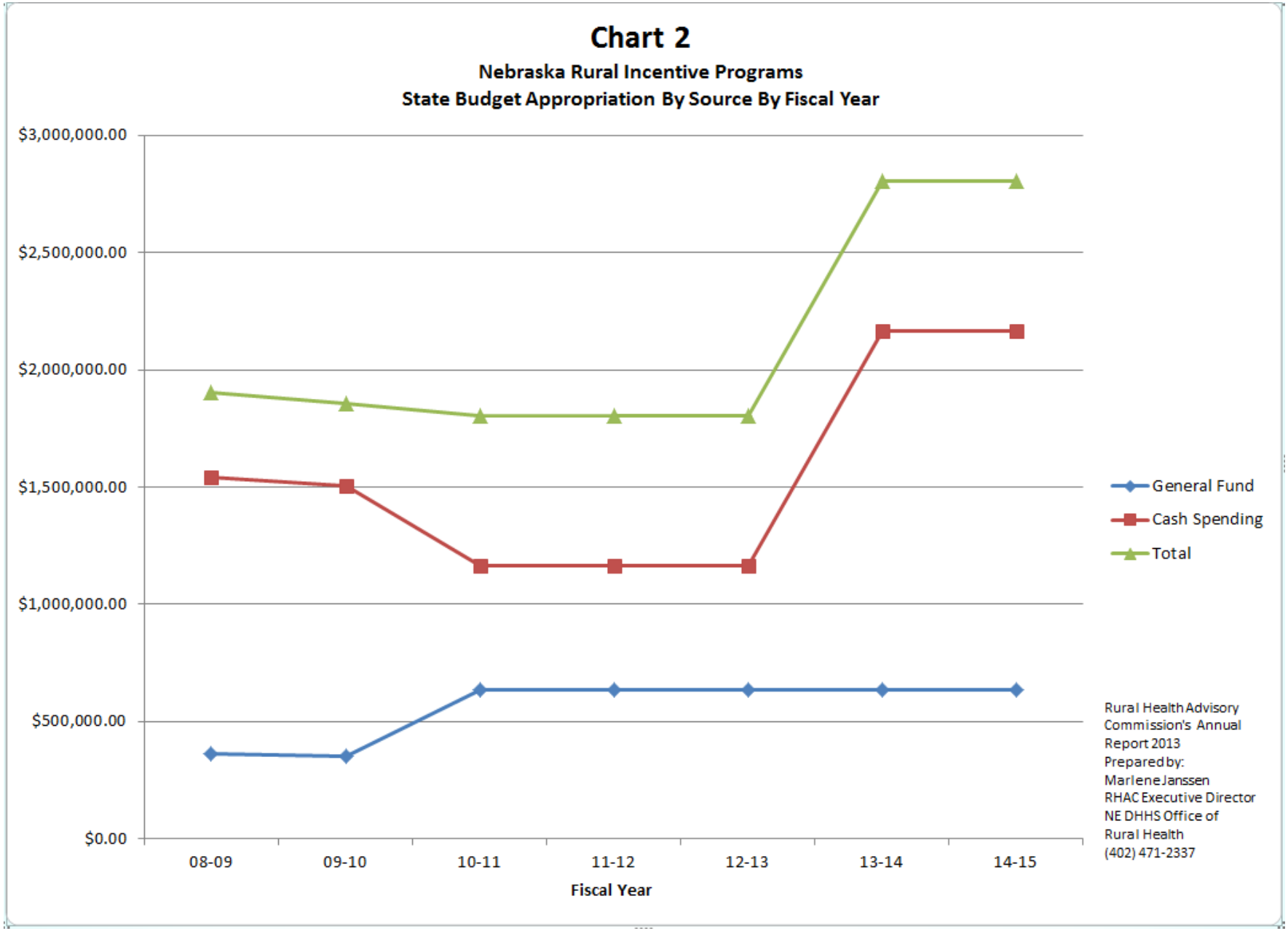
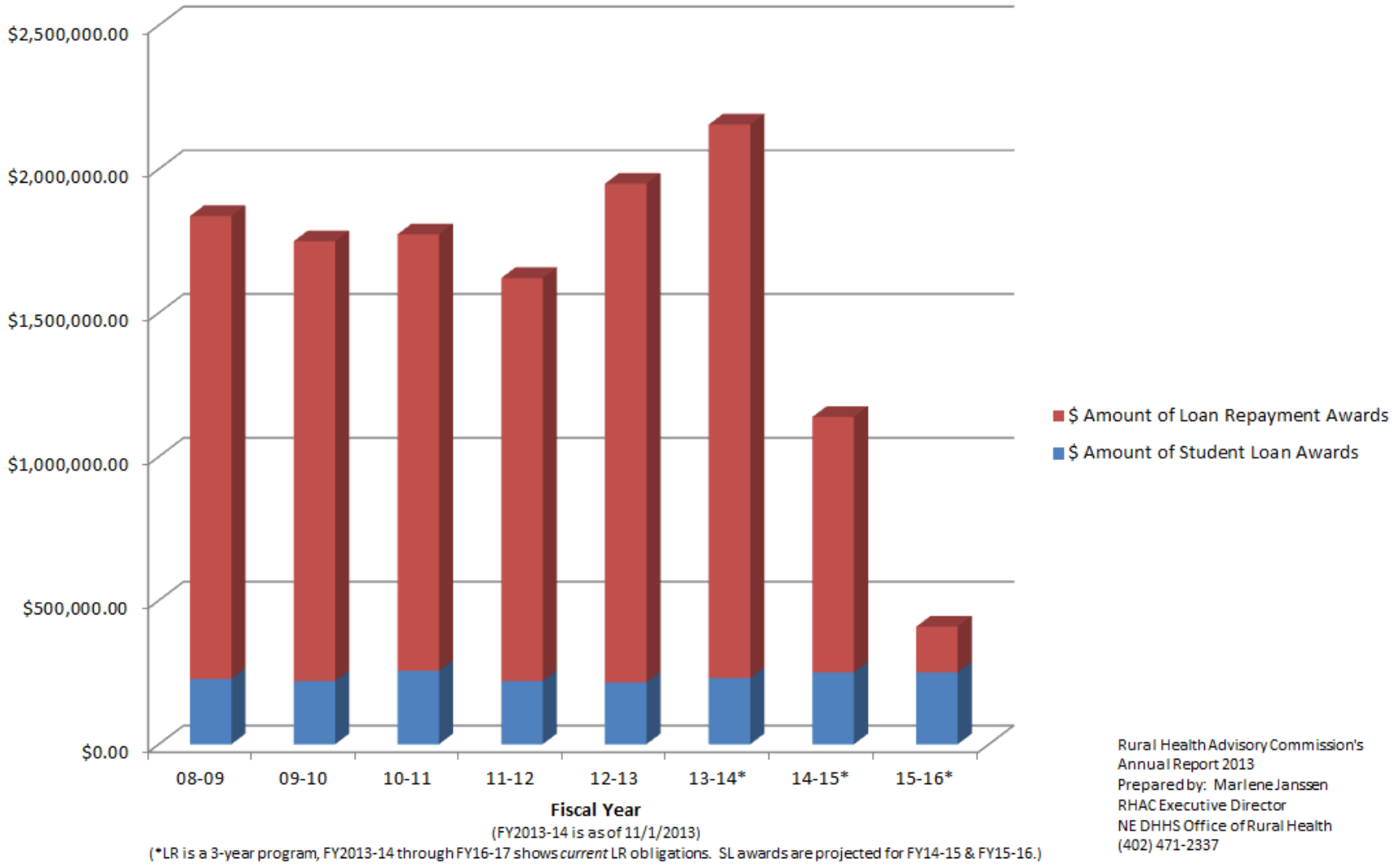


Chart 2
Nebraska Rural Incentive Programs
State Budget Appropriation By Source By Fiscal Year
$3,000,000.00
$2,500,000.00
$2,000,000.00
$1,500,000.00
$1,000,000.00
$500,000.00
$0.00
08-09
09-10
10-11
11-12
12-13
13-14
14-15
Fiscal Year
General Fund
Cash Spending
Total
Rural Health Advisory Commission's Annual Report 2013
Prepared by:
Marlene Janssen
RHAC Executive Director
NE DHHS Office of Rural Health
(402) 471-2337

CHART 3

Nebraska Rural Incentive Programs

$ Amount of Rural Incentive Awards by Program by Fiscal Year



(FY2013-14 is as of 11/1/2013)

(*LR is a 3-year program, FY2013-14 through FY16-17 shows *current* LR obligations. SL awards are projected for FY14-15 & FY15-16.)

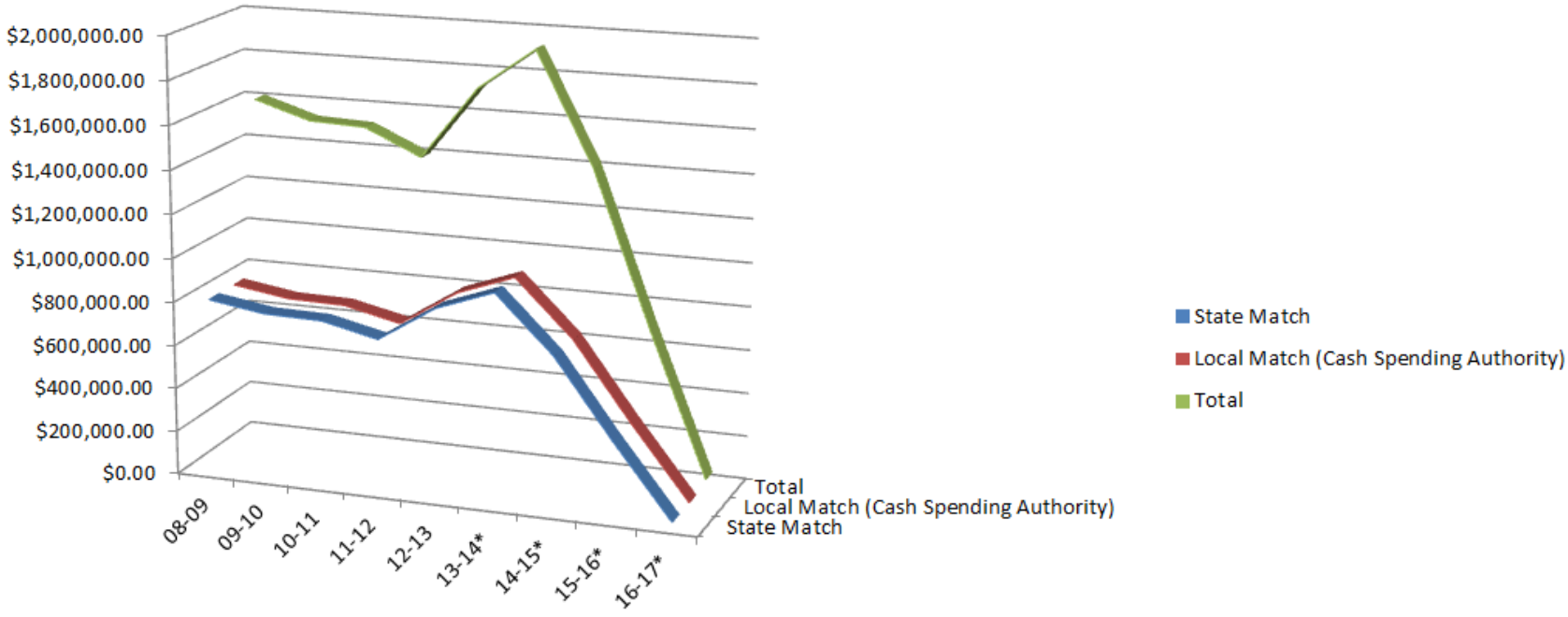
Rural Health Advisory Commission's
Annual Report 2013
Prepared by: Marlene Janssen
RHAC Executive Director
NE DHHS Office of Rural Health
(402) 471-2337

CHART 4

Nebraska Loan Repayment Program

$ Amount of Awards by Contribution Source by Fiscal Year

(Note: Loan Repayment requires a 50-50 State & Local Match. Cash Spending Authority is needed for the Local Match)

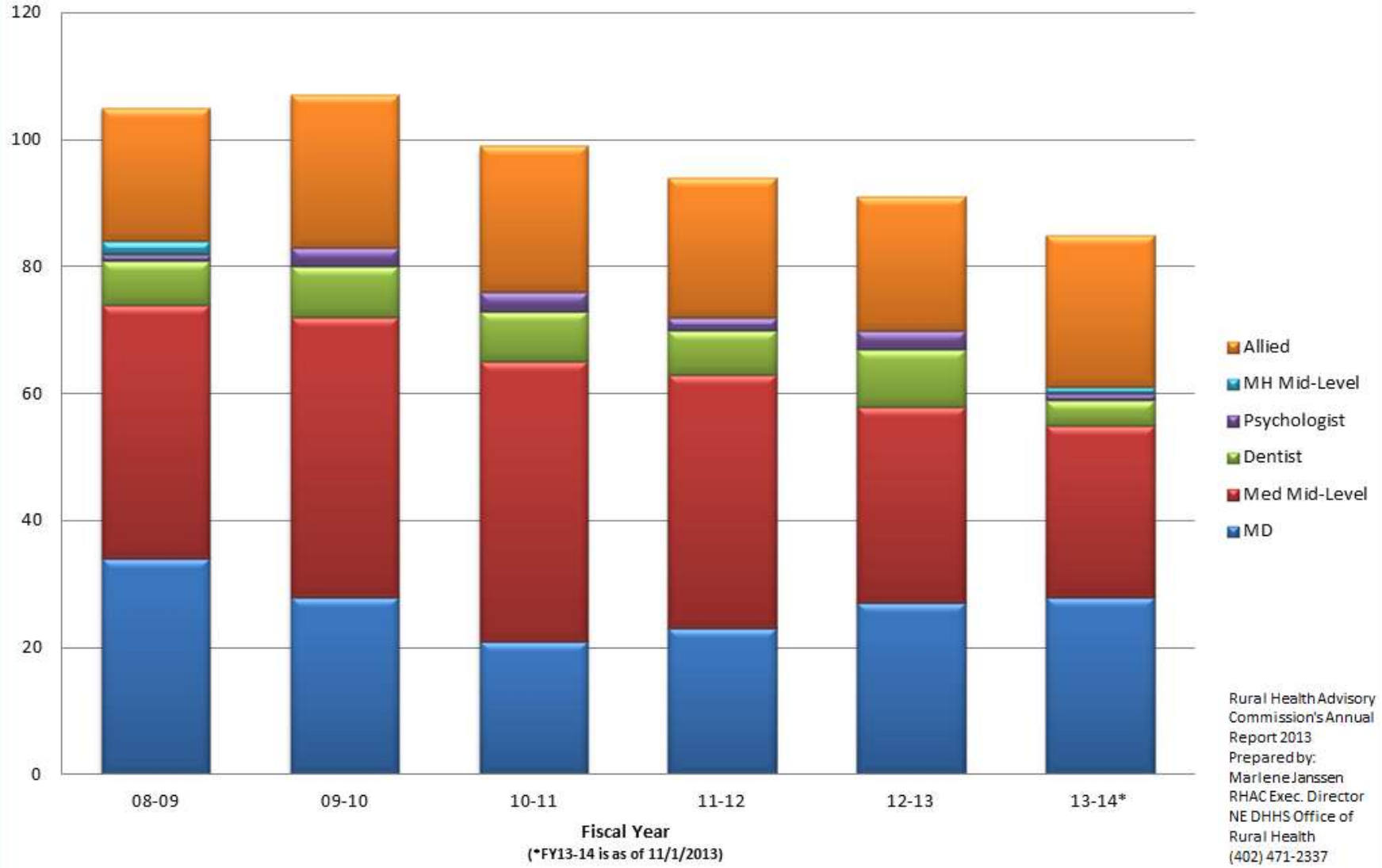


Fiscal Year

Note: Loan Repayment requires a 3-year practice obligation.
*FY13-14 through FY16-17 are based on current obligations.

Rural Health Advisory Commission's
Annual Report 2013
Prepared by: Marlene Janssen
RHAC Executive Director
NE DHHS Office of Rural Health
(402) 471-2337

CHART 5
Nebraska Loan Repayment Program
Awards by Profession by Fiscal Year



Rural Health Advisory Commission's Annual Report 2013
Prepared by:
Marlene Janssen
RHAC Exec. Director
NE DHHS Office of Rural Health
(402) 471-2337

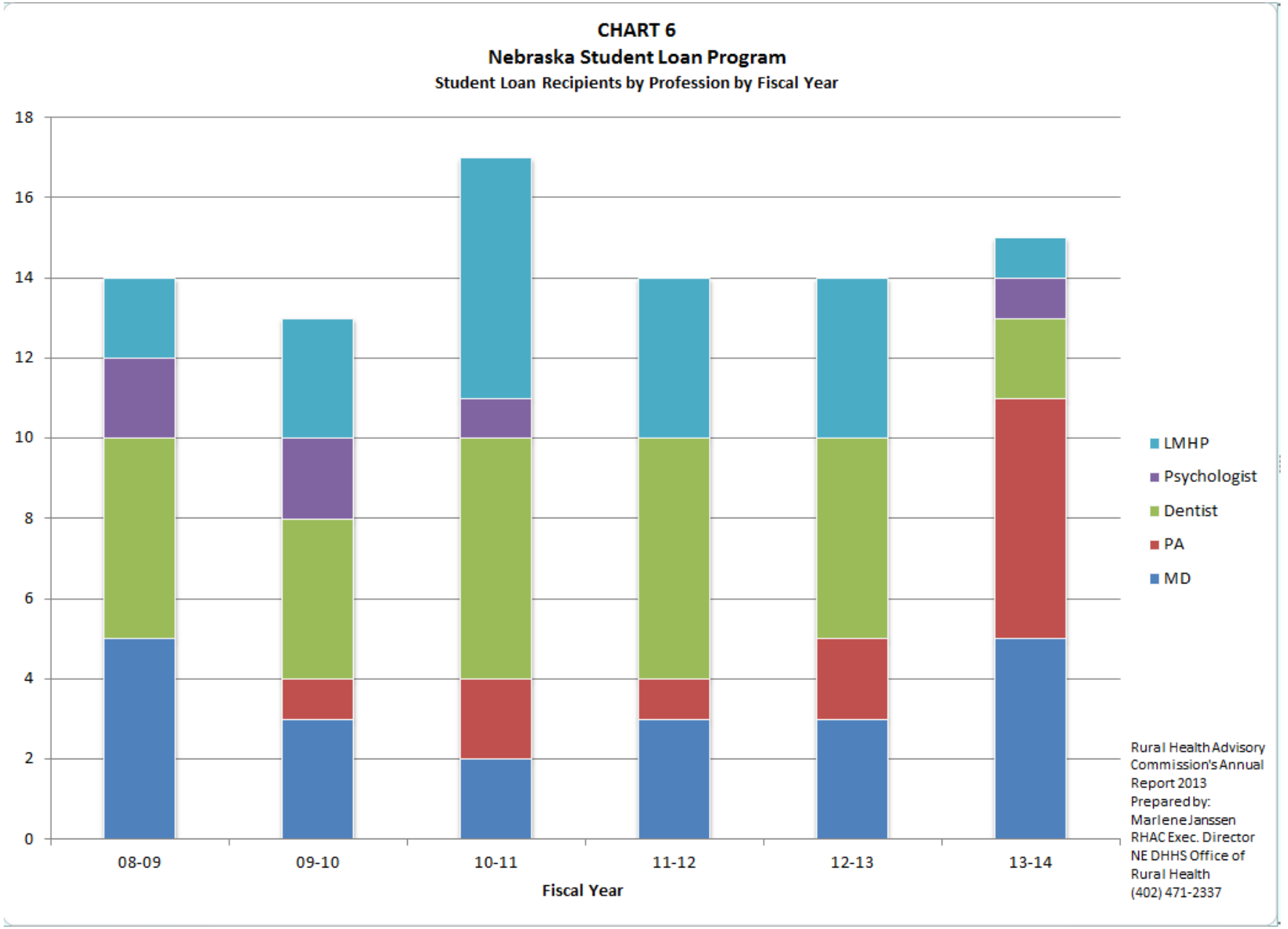


CHART 6
Nebraska Student Loan Program
Student Loan Recipients by Profession by Fiscal Year
18
16
14
12
10
8
6
4
2
0
08-09
09-10
10-11
11-12
12-13
13-14
Fiscal Year
LMHP
Psychologist
Dentist
PA
MD
Rural Health Advisory Commission's Annual Report 2013
Prepared by:
Marlene Janssen
RHAC Exec. Director
NE DHHS Office of Rural Health
(402) 471-2337

TABLE A
Nebraska Rural Student Loan Program

Number of Student Loans by Type & Outcome By Fiscal Year
(Duplicate Counts (1))

Fiscal Year	Total Amount Awarded	Student Loan Awards			In Training As of 2012 (2)	Outcomes As of 2012				
		New	Continuation	Total		In Practice Forgiveness	Completed Practice	Partial Forgiveness/ Buyout	Contract Buyout	Buyout Rate (3)
2004-05	$292,000	12	10	22	0	2	15	3	2	9.1%
2005-06	$341,250	10	14	24	0	4	15	2	3	12.5%
2006-07	$341,250	6	16	22	1	4	11	2	4	18.2%
2007-08	$236,250	6	9	15	2	5	4	2	2	13.3%
2008-09	$227,500	7	7	14	4	5	2	0	3	21.4%
2009-10	$220,000	6	7	13	6	5	0	1	1	NA
2010-11	$255,000	7	10	17	8	6	0	1	2	NA
2011-12	$220,000	6	8	14	9	4	0	0	1	NA
2012-13	$215,000	8	6	14	11	2	0	0	1	NA
2013-14	$230,000	11	4	15	15	NA	NA	NA	NA	NA
								5-Year Average Buyout Rate		**14.4%**

Footnotes:

1. Student Loan recipients may receive up to four annual loans. This means a recipient will be counted as "New" the first year and then as "Continuation" in subsequent years. Summing the "Total" student loan awards over several years will result in duplication of individuals receiving awards.
2. "In Training" means in school, residency, or provisionally licensed.
3. "Buyout Rate: is the number of recipients who buyout their contracts without ever practicing a primary care specialty in a shortage area divided by total student awards for each year. Buyout rates are not applicable for 2009-2013 since most recipients are still in training.

Historical Notes:

- In 2000, dental students became eligible to apply for the Nebraska Student Loan Program. The maximum student loan award amount was increased to $20,000 per year.
- In 2004, graduate-level mental health students became eligible for the Nebraska Student Loan Program.
- In 2009, the rural Health Advisory Commission began awarding student loans at the maximum amounts per year: $20,000 for doctorate level students and $10,000 for full-time master-level students.

TABLE B

Nebraska Loan Repayment Program

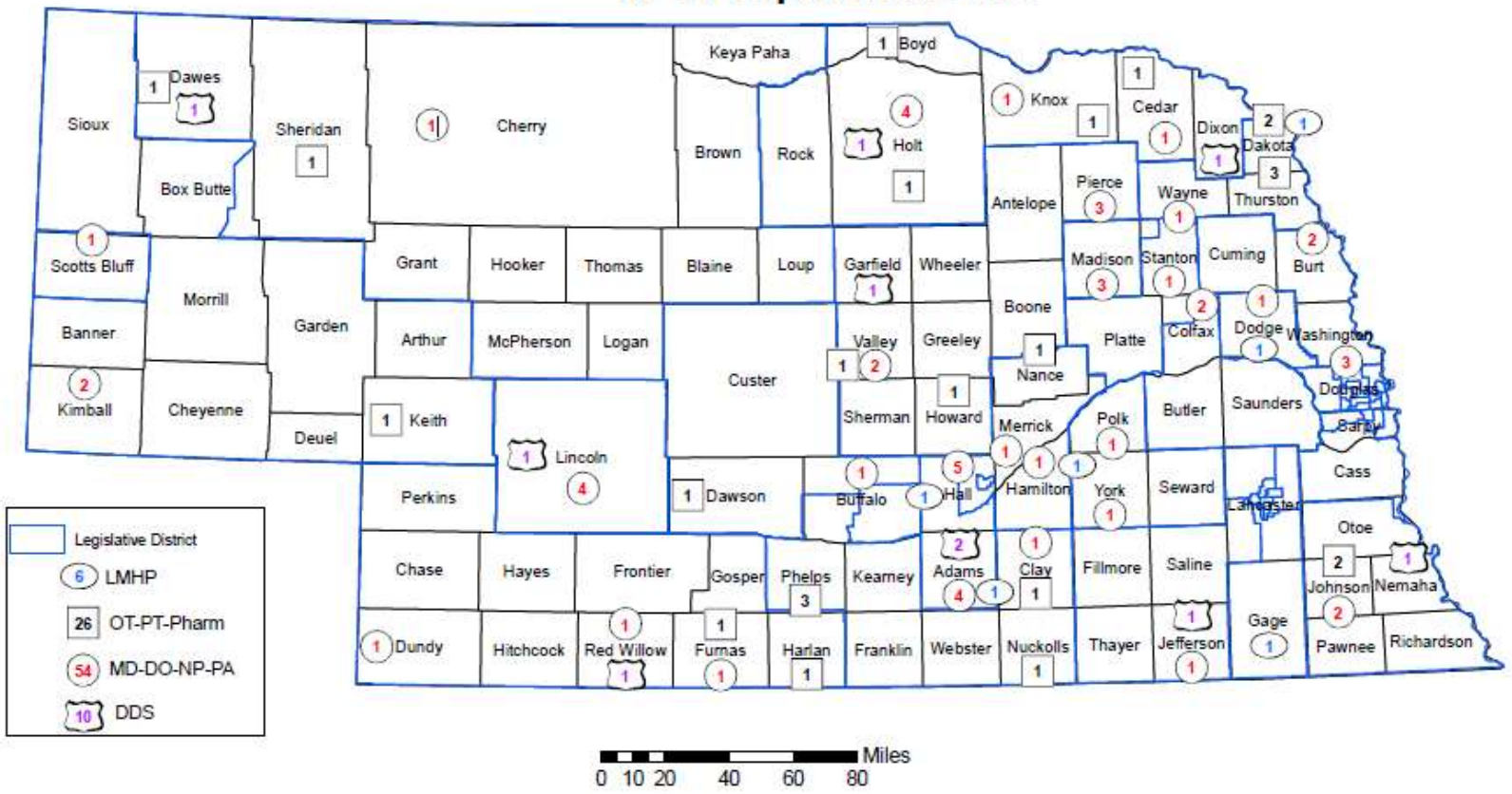
Number of Awards by Status

1994-2013

Status	Awards
In Practice Under Obligation as of 11/2013	100
Completed Practice Obligation	313
Default	36
Other	4
Total	**453**

Nebraska's Rural Incentive Programs

Nebraska State Student Loan and Loan Repayment Programs
[96] Obligated Health Care Providers
as of September 2013



Source: Rural Health Advisory Commission
DHHS - Nebraska Office of Rural Health
September 2013

Cartography: Clark Sintek | Community & Regional Planning Intern | DHHS
For: Marlene Janssen | Exec. Director, Rural Health Advisory Commission
marlene.janssen@nebraska.gov | 402-471-2337

APPENDIX A

Nebraska Rural Health Advisory commission's

Annual Rural Health Recommendations

Nebraska Rural Health Systems and Professional Incentive Act

mjansse

Rural Health Advisory Commission
September 2012

Name / Affiliation	**Appointment Designation**
Commission Chairperson: Martin L. Fattig, C.E.O. Auburn, NE	Rural Hospital Administrator
Commission Vice-Chairperson Rebecca A. Schroeder, Ph.D. Curtis, NE	Rural Mental Health Practitioner
Scot L. Adams, Ph.D., Director NE DHHS – Division of Behavioral Health Lincoln, NE	NE Dept. of Health & Human Services
Kathy Boswell Allen, NE	Rural Consumer
Brian K. Buhlke, D.O. Central City, NE	Rural Physician
Mark D. Goodman, M.D. Department of Family Medicine Creighton University Medical Center Omaha, NE	Medical School Representative
Mary Kent Humboldt, NE	Rural Nursing Home Administrator
Shawn T. Kralik, D.D.S. West Point, NE	Rural Dentist
Jenifer Roberts-Johnson Chief Administrator NE DHHS – Division of Public Health Lincoln, NE	Designee for Director, Division of Public Health; NE Dept. of Health & Human Services
Avery L. Sides, M.D. Omaha, NE	Family Practice Resident

Rural Health Advisory Commission
September 2012
(continued)

Name / Affiliation	**Appointment Designation**
Michael A. Sitorius, M.D.; Chairman Department of Family Practice University of Nebraska Medical Center Omaha, NE	Medical School Representative
Sharon Vandegrift, R.N. Fairbury, NE	Rural Nurse
Roger D. Wells, PA-C St. Paul, NE	Rural Physician Assistant

Staff Assistance Provided by:

Marlene A. Janssen, RHAC Executive Director
Nebraska Department of Health and Human Services
Office of Rural Health
P.O. Box 95026
Lincoln, NE 68509-5026
(402) 471-2337
http://dhhs.ne.gov/publichealth/Pages/hew_orh.aspx

RURAL HEALTH ADVISORY COMMISSION
Annual State Rural Health Recommendations
As per §71-5659 NE Revised Statutes

Vision Statement:

All rural Nebraskans have access to a dynamic, integrated health and health care system meeting all of their physical and mental health needs.

In the face of the changing local, state, and national health care environment, the Nebraska Rural Health Advisory Commission (RHAC) has drafted the following 2013 state rural health policy recommendations, as required by statute, to present to the Governor, the Legislature, the Nebraska Department of Health and Human Services, and the citizens of our State.

Each year, the Rural Health Advisory Commission considers the past, current, and future health care access and utilization issues our state's rural communities and residents are or will be facing. We focus on our communities because we believe that our communities matter to their citizens and to all of us who live in this State. One of the most important priorities every community must address is the health and health care accessibility for their residents.

The number of primary care providers in the State continues to decrease despite the State's increasing need. These needs are even more prevalent in our rural areas, where providers must do more with fewer resources and support than their urban counterparts. Many health care providers begin their educational journey with the dream of returning to the rural areas in which they were raised. Sadly, this goal many times remains unattained due to the many difficulties facing providers in rural areas. Lower reimbursement, longer hours, and more commitments are there to rudely greet the new rural provider, along with ever increasing levels of student debt.

The rural health incentive programs serve to eliminate one of the major barriers in retaining and attracting young providers to return to their underserved rural areas. These programs play a vital role in providing continued access to health care in some of the most rural areas of the State. With a default rate of less than 12% (meaning that 88% of recipients fulfill their obligation to practice in a rural or underserved area), the tremendous success of these programs is instantly recognizable through the benefits to the community in health care and positive economic impact.

"Student debt has been increasing at a rate much higher than inflation, and many graduates are facing huge debt loads of greater than $200,000. As recently reported, total student debt in this country now amounts to more total dollars than America's total credit card debt! This alone is swaying people away from primary care medicine in general, regardless of practice location. The student loan repayment programs not only serve to place providers in rural and underserved areas, but also help in attracting students to pursue primary care fields from the very beginning of training. If I am honest, I must question whether I myself, would have chosen primary care without the reassurance of these types of loan repayment programs. Along with my fellow classmates, I have begun to look for the practice location where I can make the greatest contribution to my home state. Many of us have roots in small, rural towns, and have turned back to those roots, because of the sense of home they provide. The loan repayment offered by

these programs allows all of us who have ever had a dream of returning to a small rural community as a family practitioner, the opportunity to do so without the burden of mounting debt." – Zach Frey, M.D., former RHAC member

The Rural Health Advisory Commission has developed the following recommendations crafted from a researched perspective and with the knowledge that it will take partnerships between communities, between communities and their governments, between communities and their health professionals, and all of the other partners who have a stake in the rural places and people of our State. The issue is *access* to health and health care, and we respectfully ask your partnership in helping our rural communities to have that access.

Recommendations:

I. Incentive Programs for Rural Health Professionals

A. The Rural Health Advisory Commission (RHAC) strongly advocates for maintaining financial support of the state's incentive programs (student loans and loan repayments) for statute identified rural health professionals. The Commission also supports the continued assessment of health care provider shortages, especially primary care physicians listed in the Rural Health Systems and Professional Incentive Act: family practice and general surgery, physician assistants, pharmacists, advanced practice nurses, dentists, licensed mental health professionals (LMHPs), psychologists, psychiatrists, and physical and occupational therapists. We also support alternative incentives to remove barriers in recruitment and retention of these health care providers. Since 1994, 416 health professionals have or are participating in the Nebraska Loan Repayment Program with over 91% completing their practice obligation.

For the last few years, the National Health Service Corp (NHSC) loan repayment program benefited a number of rural practitioners in the state. This program has now changed its qualification criteria in such a way that many underserved areas of Nebraska no longer score high enough to qualify for the incentives. The State of Nebraska needs to increase the funding for the state incentive programs to offset the loss of funding from the NHSC program. A relatively small amount of General Funds is used for these programs not only to increase access to health care services but also create new jobs in the communities.

1. a. The Commission encourages the continued support, utilization and enhancement of the present rural health incentive programs managed by the Nebraska Office of Rural Health.
   b. The Commission strongly encourages maintaining the current state general funds appropriation level for the coming biennium budget for the incentive programs, (student loans and loan repayments) which would include replacing and enhancing the $250,000 in Merck settlement money with state general funds. (FY2011-12 was the last year of the Merck Settlement cash of $250,000.)

2. a. The Commission recommends that affected/invested stakeholders participate in

health care workforce studies and meet with, or communicate to, the Commission a review of their findings; and then to work at the creation of an encompassing strategy and work plan to address identified workforce shortages.

b. The Commission supports the development and operation of the Nebraska Healthcare Workforce Center that would be the trusted source of data related to current and future workforce shortages so that proactive solutions to resolving the shortages could be developed.

II. Behavioral Health Services:

Behavioral health care in rural Nebraska continues to be a major concern for the Rural Health Advisory Commission. There continues to be a shortage of mental health providers in most rural areas which results in many problems, including the fact that rural Nebraskans must drive long distances for treatment. The Commission supports and provides incentives for community based behavioral health providers. The Commission encourages an integrated health delivery system such as the medical home model that addresses both medical and mental health needs and resources. The Commission realizes the importance of the continued need to recruit behavioral health providers and recognizes the importance of retaining providers who are presently serving rural areas. The Commission supports the development of resources and reimbursements that can help assure the recruitment and retention of behavioral health providers to Nebraska.

A. Community based mental health workforce issues should be addressed through:

1. Maintaining or expanding funding for current state incentive programs for behavioral health workers including:
    a. supporting legislative efforts to maintain and strengthen present programs,
    b. assessing and developing alternative funding sources, and
    c. working with existing workforce development programs and resources.
2. Evaluating present provider reimbursement issues and developing recommendations to update payment models.
3. Supporting an integrated, new innovative model of care utilizing present behavioral health or medical providers in new roles and systems.

B. Medicaid reimbursement for behavioral health providers in rural areas needs to be addressed through:
1. Reasonable reimbursement incentives for behavioral health providers practicing in rural areas.
2. Support and update payment reimbursement models for unique rural issues including:
    a. transportation and travel costs;
    b. payment reimbursements for integrated services including new project models; and
    c. payment issues to support the use of telehealth services or other electronic means of telemedicine.
3. Evaluating present Medicaid reimbursement issues and offering recommendations, as

appropriate.

III. Integrated Service Delivery and Training Systems

The Rural Health Advisory Commission supports the creation of a sustainable unified reimbursement model to help advance health care system integration for rural communities and individuals. This model would be developed by a group of professional inclusive stakeholders. We believe the most effective health care delivery model of the future will include:

A. Integrated networks;

B. Professional collaboration (in some communities this may include: school nurses, caregivers, skilled nursing facilities, public health officials, dentists, home nurses, mental health professionals, parents, consumers, teachers, day care providers, community activists, civic organizations, blood bank organizations, chiropractors, physical therapists, pharmacists, advanced degree nurses, physician assistants and physicians, to name a few);

C. Patient centered medical home model of care delivery or other proven rural provider model; and

D. Community involvement.

The Commission encourages all in-state health professional education programs to include training experiences in rural areas to assist providers in understanding the navigation and delivery of care in rural parts of our state.

The Commission continues to predict a rural health provider shortage for the foreseeable future. We invite continued thoughtful solutions and strategies to address statewide distribution, education/training and access to health care for all of our State's residents. This prediction is based on a large number of retiring health professionals, the expansion of insurance coverage, and decreased number of Medicare providers which will increase the demand for health care services at all levels and of all professions.

IV. Rural Emergency Medical Services

While progress has been made towards integrating rural EMS, the industry still has important goals to achieve the recommendations made in the 2006 Institute of Medicine report, "The Future of Emergency Care". The report proposed that future EMS efforts focus on emergency health care delivery in a manner that is area focused, coordinated and accountable. Those efforts will involve EMS working with multiple systems in all arenas, including local, state and federal levels to "enable continuous communication and enhance the benefits of overall system integration, including better and safer patient care."

Failure to integrate EMS into local systems of care and into regional and national networks is likely to result in ongoing deterioration that further limits availability and access to advanced

EMS care in rural and frontier areas, Nels Sanddal, longtime EMS researcher and Manager of Trauma Systems with the American College of Surgeons (ACS), asserted. But integration is only one component in the future viability of rural EMS.

“I don’t think the EMS volunteer model is sustainable over the long run for a variety of reasons,” commented Sanddal. “The economy has driven more working people to larger communities. Younger people still living in small communities often commute and are unavailable during daytime hours. And employers are reticent to allow an employee to leave work when they realize transports may take that employee away for several hours.”

Twenty percent of EMS leaders in the NCRHR-PAC report were uncertain of their ability to maintain future service and 8 percent were labeled "frankly pessimistic." They indicated that volunteer recruitment would likely be the largest deciding factor.

"The need for pre-hospital care in small communities continues to be recognized and met by local residents and local officials who stepped up when market-based solutions were not available," the report concludes. "In a significant number of areas, however, the ability of community volunteers to provide emergency services is being stretched to the breaking point and requires new creativity. Consolidation of local services to benefit recruiting and to increase run volume and revenue must be considered. Although rural volunteer EMS grew locally from local need, the need to work together with other EMS agencies or other health care providers in systems of care is inevitable and offers options to maintain these important services."

The Commission Recommends:

A. The development of a state wide EMS system to support a comprehensive program for pre-hospital care, ranging from in-home care, trauma to national emergency preparedness.
B. Research and identify models of a statewide critical patient care transport system addressing inter-facility advanced life support transport of patients from rural hospitals to a more appropriate advanced level of care.

C. Study the feasibility of developing a statewide program to utilize the skills of “Out of Hospital Emergency Care Providers” within their scope of practice to provide care in partnership with other health care providers to patients living in their homes or other facilities in their community. The foundation of this study would be the Community Para-Medicine model.

D. The Commission recognizes the need to develop and pass legislation designating a governmental entity or oversight body at the local level to assure pre-hospital care will be provided at the local level.

V. Rural Communication and Information Technology Systems

The Commission encourages the continued improvement of telecommunications technology

across all areas of the state to support the sharing of health information in a patient information secured environment. Emphasis needs to be given to assuring that the band width of the telecommunications infrastructure is adequate to meet all of the health care needs in the state.

A. The Commission recommends that the Nebraska Department Health and Human Services work with advanced rural telehealth network models to identify best practices that can be duplicated in other areas of the state.

B. The Commission strongly encourages the use of telecommunications for consultations, education, and electronic health information delivery to and from homes, hospitals and other health care providers.

C. The Commission recommends development of strong telecommunications linkages between public health departments, area hospitals, and other health professionals to address district-wide, regional, and statewide health needs.

D. The Commission supports the use of electronic health record (EHR) technology by all health care providers and the secure sharing of patient information through health information exchanges. Even though some of these exchanges have already been developed, alternative systems need to be explored to ensure that the best systems are in use and that those systems are designed in such a way that the business model that funds them is truly financially sustainable.

E. The Commission strongly encourages the use of standardized protocols for all reporting, transmitting and the exchange of all health care data.

F. The Commission also recommends that state agencies develop the capacity to send and receive important patient information that certified EHRs are required to transmit and receive.

VI. Rural Quality

The Rural Health Advisory Commission supports efforts to improve the quality of health care provided in rural areas. The Institute of Medicine (IOM) report entitled, "Quality through Collaboration: The Future of Rural Health" outlines an excellent agenda for achieving this goal. The Affordable Care Act (ACA) also calls for the development of a National Healthcare Quality Strategy to be developed. This strategy may have a significant impact on the quality efforts of all providers, especially those in rural areas. The Commission believes that Nebraska is in a position to be a leader in the implementation of this agenda, once it is defined. It also supports the efforts of health care providers (physicians, health departments, home health, Advance Practice Nurses, dentists, mental health providers, etc.) to join the Nebraska Coalition for Patient Safety and participate in the reporting of adverse events and "near misses" as defined by the Coalition as reportable events

A. To achieve this higher quality standard, the RHAC will:

1. Testify and provide additional information to the Legislature and appropriate subcommittees about the need for health care delivery changes.

2. Identify the additional primary care needs/solutions for the next 10 years in all health care professions in order to provide satisfactory health care to rural Nebraska residents.

3. Promote continued research into utilizing, developing, and applying rural health care models in rural health settings.

B. Recommendations:

1. Encourage developing partnerships with local businesses to provide health care clinics for the underserved, uninsured, under insured, chronic illness cases, and returning war veterans.

2. Encourage and support Universities and Colleges in establishing rural residency programs within rural health care systems. Rural residency programs should include medical, nursing, dental, mental health, pharmacy, business schools, public health, occupational health, rehabilitation students and other graduate schools that contribute to rural health.

3. Encourage apprenticeship/internships in collaboration with health clinics in rural areas from business, public health, law, information technology (IT), and marketing students.

4. Encourage and provide financial incentives to support telehealth medicine.

5. Encourage and provide financial incentives for rural health care providers to continue involvement in Quality Improvement Organization programs.

6. Promote and reward broader case management concepts that increase Registered Nurse services for the underinsured, uninsured, vets, etc. in rural Nebraska.

7. Encourage and support the medical home concept for high end users of emergency rooms for health care services and hospital re-admissions.

8. Support and reimburse the use of local public health departments in developing and sustaining medical homes for high end users of medical services.

9. Encourage and provide financial support to home health departments in providing follow care and education to elderly who are not home bound. Support research and models that promote the use of home health departments for those patients not home bound.

VII. Strengthening Rural Health Services by Improving Access to Affordable Health Care

Many additional health disparity issues continue to be found in our rural communities. The recruitment/retention of providers, the maintenance of facilities, loss of population, and the cost of care/drugs for lower income patients are but a few issues facing rural Nebraska.

A. The Commission recommends:

1. The creation of a new, proven, payment template for an integrated network service model. (This totally integrated model should be designed to help providers transition from pilots to successful integration.)

2. Review of the opportunities for Nebraskans to obtain health care insurance coverage through the Health Insurance Exchanges created by the national health reform legislation.

3. Highest consideration should be given to providing access to and payment assistance for the needed health care for all rural Nebraskans. This should be done with the cooperation of governments at all levels. It may include increased use of community health care workers such as, community paramedics, nurse centers, and mid-level practitioners, using existing local public health departments, and evidence-based health-care practices.

VIII. Rural Managed Care and Reimbursement

The Commission believes that reimbursements of health services provided drive the successful models for health care delivery within our state; therefore:

A. The Commission supports the development of a Medicaid rural "Primary Care Team" model, with attractive reimbursement, for those providing all primary care services to rural communities (Medical, Dental, Behavioral Health, etc.).

B. The Commission recommends that the Legislature fund potential new rural care delivery models and assist with a rural impact study to identify outcomes.

IX. Veterans Care

The majority of soldiers returning from the wars come from our rural communities, which often lack the needed professional health care providers to assist them with the many injuries they may have received. Steps must be taken to make sure that these soldiers, who have served their country so well, are able to receive the care they need and deserve as close to their home as possible.

Presently 28 percent of all Veterans live in rural America and since 2006, the number of Veterans utilizing the Veteran's Administration (VA) Health Care system has increased by 15

percent. Twenty-six (26) percent of these patients are over the age of 75 years. This strain on the VA health care system will continue over the next few years and present challenges to access and increase the use of private emergency care systems.

According to the VA Office of Rural Health, the access to health care services is limited by the distance to care, limited transportation options, the lack of specialty care and rural providers, a poorer, sicker and older population, the lack of mental health providers, and lack of understanding by the veteran.

The VA Medical System has increased the utilization of rural providers and has started new rural clinics, but access still remains limited and the understanding of access avenues is still lagging behind other medical resources such as Medicare and Medicaid.

It is recommended that the Rural Health Advisory Commission work with the Department of Health and Human Services, the local rural health departments, interfaith ministries, and the VA Office of Rural Health to develop a comprehensive program to educate and enhance veterans' access to care in Nebraska, especially in the area of mental/behavioral health.

Issues to be included may be:

A. A liaison between the Veterans Administration and rural health care services needs to be created to better serve all veterans and their families living in rural areas.

B. VA contracts are difficult for primary care clinics, hospitals, and long-term care facilities to obtain causing veterans in rural areas to be moved away from their homes for long-term care. If veterans choose to stay in rural areas close to their home, they do not receive the benefits other veterans in more populated areas receive.

C. The liaison created between the Veterans Administration and rural health care providers should work to outsource long-term/short-term in-house rehabilitation to centers in the veteran's respective communities. The outsourcing could also occur with mental health providers who could be educated through the Veteran's Administration outsourcing liaison concerning specific issues veterans may encounter (i.e., post-traumatic stress disorder).

D. Veterans' health benefits need to be reviewed to determine how they may better be distributed in rural areas while using cost-saving measures. One way this could be accomplished would be adjust veterans' benefits to more closely mirror Medicare benefits while at the same time, making them more available to all veterans in all communities.

X. Elderly

With the decline of services and population in the rural areas, the elderly population is facing an ever increasing-challenge in obtaining medical and home health care. Caseworkers are no longer individuals from the community the elderly can trust, relate to, and count on for answers. Many health issues require a specialist who may be over 50 miles away. Many

small villages and communities do not have public transportation to assist the elderly in getting too much-needed appointments.

Issues to address include:

A. The technological requirements from government entities to complete applications and request information online can be an impossible request for elderly citizens who do not have computers and do not have a caseworker in their community to visit or call for assistance. Agencies providing assistance to obtain health care to include Medicare and Medicaid need to make available liaisons between the elderly and the agencies to bridge the gap created by technology. Lack of these much-needed liaisons can be life threatening.

B. A review through Pharmacy Board needs to be initiated to find a way to supply medications that are being destroyed that have orders and are clearly labeled to Medicaid recipients. It would also be beneficial to supply these unused medications to individuals who fall in the donut hole or do not have Part D coverage. The thousands of dollars of waste caused by this regulation could be used to better assist our elderly population.

C. Look into creating a system where healthy Medicaid recipients assist elderly or disabled Medicaid recipients' needs in the rural areas such as transportation to doctor's appointments as a condition to receiving Medicaid assistance.

D. An open dialogue needs to be created and sustained between the Medical Director's Association and the long-term care survey process in the State of Nebraska. The focus of survey must be to provide the best care possible for the elderly of Nebraska. The best avenue to achieve this would be a collaborative process versus a punitive process. One example of this being; when nursing facility residents receive orders for multiple drug therapy from their physicians, nursing homes are being given deficiencies for an unnecessary drug therapy tag. Physicians should not be afraid to write the best therapies for their clients and facilities should not be put in the middle of the doctor/patient plan of care.

"Access to health care" is not a simple provider office, especially for the rural elderly. This "Access" includes:

- Recognition of need for prevention and treatment of medical care
- Transportation to and from a facility
- Appropriate type of provider and testing
- Sharing of information through IT to multiple providers
- Opportunity for appropriate treatment options and medications
- Monitoring of the treatment and or post hospitalization care
- Reimbursement for the providers and health care facility

Elderly patients tend to be sicker, less mobile, and have less available income. Providers now face less reimbursement for their care and many are restricting their practices to the total

number of Medicare beneficiaries being treated on a daily basis. This triad of issues is restricting access to appropriate health care services.

The Nebraska Rural Health Advisory Commission recommends the following:

A. Establishment of a "team approach" training program for present health care providers and provider facilities to train medical teams to provide and care for the at risk elderly population in Nebraska.

B. Encourage local rural health departments to hire care coordinators to identify local patients and assist local providers about available resources such as internet access for health care programs and remote "virtual visits" by home health and providers.

C. Allow and train primary care providers, dentists, mental health providers, pharmacists, paramedics, etc. to utilize telemedicine as a reimbursable medical care modality for all levels of care including emergent, nursing home, and personal residence visits.

D. Develop training initiatives for providers specific for the elderly including such topics as nursing home medical treatment guidelines, pharmacy modifications for the elderly, treatment of the elderly trauma patient etc.

E. Assist the workforce in the retention and the recruitment of health care providers for all aspects of care including dental, mental health, social services, transportation (EMS), etc.